A HEALTH CARE REFORM AGENDA — PAGES 10-11

Welcome NAHU Members! PAGE 5

Health Care News

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States Tackle Medicaid

JOE MOSER

Michigan's state budget deficit could approach $2 billion in the next fiscal year. Eleven other states are on pace to see deficits at or over the $2 billion mark. In Illinois and Wisconsin, the budget gaps may be closer to $3 billion. New Jersey's is $4 billion, Texas's as much as $8 billion, and California's $25 billion.

According to the National Conference of State Legislatures (NCSL), two-thirds of the states have reported revenue collections for the early months of the 2003 fiscal year are below forecasted levels. New York, for example, estimates a revenue shortfall of up to $10 billion over the next two years.

While state revenues are slumping, expenditures on Medicaid are increasing at a rapid pace. They are a driving force behind the budget deficits most state legislatures are facing as they open their 2003 sessions.

Reducing Eligibility Benefits

Medicaid spending increased by 13.3 percent in fiscal year 2002 and 10.6 percent in fiscal year 2001. Total revenue growth over the same period was just 5 percent, according to the National Association of State Budget Officers.

The gravity of the problem becomes apparent when one realizes Medicaid spending comprises more than 20 percent of all state expenditures. The situation is not sustainable; to bal-

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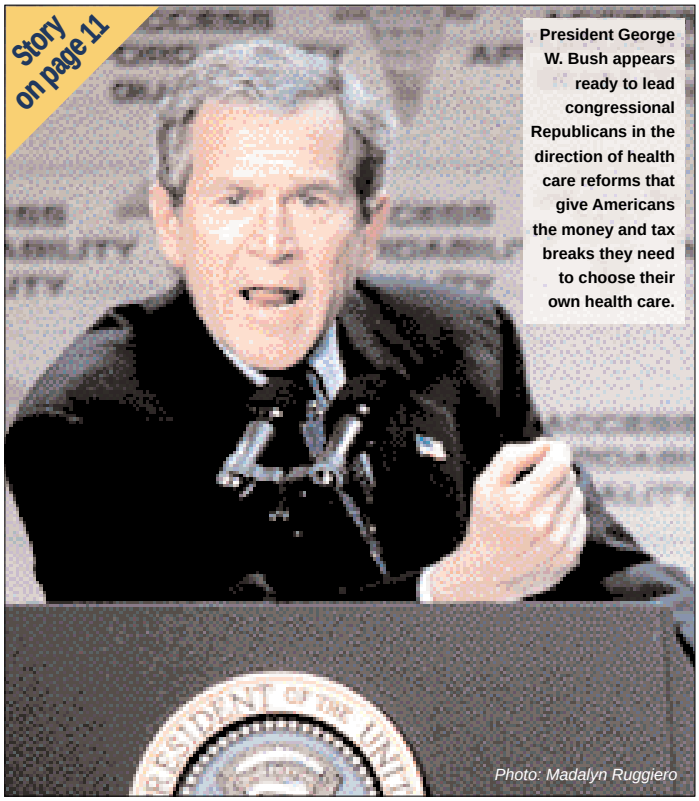

President George W. Bush appears ready to lead congressional Republicans in the direction of health care reforms that give Americans the money and tax breaks they need to choose their own health care.

Cloned Baby Claim Reopens Policy Debate

CONRAD F. MEIER

On December 27, 2002, spokespersons for Clonaid claimed to have produced a 7-pound girl named Eve, born to a 31-year-old American woman outside the U.S. Most scientists and journalists greeted the claim with disbelief, but government officials and policymakers are taking the matter seriously.

"The President believes, like most Americans, that human cloning is deeply troubling," said new FDA Director Scott McClellan. "Despite the widespread skepticism among scientists and medical professionals about today's announcement, it underscores the need for the new Congress to act."

In its initial announcement, Clonaid said it would take DNA samples to prove the child was a genuine clone. The company has since withdrawn that pledge, saying the mother feared legal action that would take away the child. Michael Guillen, a freelance journalist who had agreed to oversee the DNA testing by a team of scientists, told *USA Today* reporters he has suspended his efforts.

The company says it has a list of 2,000 people willing to pay $200,000 to have themselves or a loved one cloned. It claims at least four more cloned babies will be born in the next few months.

Clonaid was established by the Raelian movement, a religious group that believes aliens landed on Earth 25,000 years ago and started the human race through cloning. The founder

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Maine Rx Discounts Are Illegal, Court Rules

Appeals court rejects plan designed to replace one being reviewed by U.S. Supreme Court

CONRAD F. MEIER
AND DIANE CAROL BAST

The U.S. Circuit Court of Appeals for the District of Columbia on December 24, 2002 rejected the Healthy Maine Prescriptions program launched in June 2001. The decision represents a victory not only for pharmaceutical companies, but also for consumers, who would have paid for the new entitlement with higher drug prices and restricted access to innovative new drugs.

"We recognize the desire of states like Maine and Vermont to help seniors pay for their prescription drugs," noted Marjorie Powell, assistant general counsel for the Pharmaceutical Research and Manufacturers of America (PhRMA), which had brought the suit. "But these programs are the wrong way to do it. States should work with us to urge Congress to pass a Medicare prescription drug benefit this year."

Unapproved Expansion of Medicaid

Taking advantage of a Section 1115

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Senator Bill Frist (R-Tennessee)

Frist's "Big Vision" Gets Bigger

CONRAD F. MEIER

Last month, this column reported on Tennessee Republican Senator Bill Frist's "Big Vision" for Medicare reform. We did not expect at the time that he would soon be occupying the powerful seat of majority leader of the U.S. Senate.

Frist, 50, a heart-lung transplant surgeon, first entered politics in a successful bid for a Senate seat in 1994. He swiftly gravitated to the top in an institution that usually honors seniority.

According to the news service Reuters, Frist comes from a wealthy family with deep roots in Tennessee. He was educated at Princeton and Harvard and became a pioneering multi-organ transplant surgeon, establishing the transplant program at Vanderbilt University Medical Center.

In 1994, he embraced politics, saying he wanted to be a citizen-legislator walking the line between the worlds of medicine and public policy. He quickly became a mover and shaker, first as a prominent Republican voice on health care issues and later as George W. Bush's liaison to the Senate during the 2000 Presidential campaign. Most recently, Frist headed the Senate Republican campaign committee during the 2002 elections that led to the Republicans' winning a majority.

Ties That Bind

The anthrax letters sent to the Senate in late 2001 further elevated Frist's public profile. He served as a calm-headed liaison between the Senate and anthrax health experts, explaining the science in layman's language and preventing a panic.

Carl Feldbaum, president of the Biotechnology Industry Organization, told the media, "We have found him to be an extremely good leader, particularly on scientific issues, able to explain often arcane intricacies to other members of the Congress who are not scientists."

In a strange twist of fate, given the role Senator Strom Thurmond (R-South Carolina) played in bringing down former Senate Majority Leader Trent Lott, Frist helped revive Thurmond when he collapsed on the Senate floor at age 98. Frist has also treated numerous people who became ill while visiting the Capitol over the years; helped save the life of the gunman who was shot after killing two Capitol policemen in 1998; and on January 1, 2003 helped save the lives of two auto accident victims in Fort Lauderdale, Florida.

> **"With health care expected to be at the top of the domestic agenda this year, [Tennessee Republican Senator Bill] Frist is in the right place at the right time."**

Health Care Reformer

With health care expected to be at the top of the domestic agenda this year, Frist is in the right place at the right time. He will steer the Senate's work on such key issues as Medicare reform and prescription drug benefits and will help define new approaches to the uninsured problem.

Frist backs a ban on the controversial procedure known as "partial-birth abortion" and generally backs Bush's framework for limiting stem cell research.

One of the first controversies Frist faces is a provision, slipped into the homeland security law, barring lawsuits over whether a mercury-containing preservative in childhood vaccines causes autism. A bipartisan group of lawmakers has vowed to repeal the provision as soon as possible. Frist generally supports the lawsuit ban, and he wrote a similar version earlier. But his version was part of a much broader bill that would have revamped vaccine injury compensation as well.

Health Care Connection

The Frist family fortune comes from Health Care America (HCA, now known as HCA The Healthcare Company), a for-profit hospital chain, which his father and brother founded in 1968, while Frist was still a teenager.

HCA later merged with Columbia Health Care, becoming engulfed in an extensive and prolonged Medicare fraud investigation that led to big civil fines as a result of behavior attributed to Columbia. A criminal probe was dropped, and the investigation did not focus on Frist's relatives. The Senator himself did not help run the company and was never implicated in any wrongdoing.

Democrats have claimed Frist is overly sympathetic to the causes of pharmaceutical companies and are likely to try to tarnish his reputation by continuing to demonize drug companies.

Pharmaceutical companies used to split their donations somewhat evenly between Democrats and Republicans. But now, with Medicare and drug patent reform on the table, the industry trend is to give more than they used to, and mostly to Republicans.

Conrad F. Meier is managing editor of Health Care News.

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Surgeons Protest Liability Premiums

West Virginia surgeons walk out to call attention to growing crisis

CONRAD F. MEIER

The debate over malpractice insurance reform took a dramatic turn in January, as surgeons at four northern West Virginia hospitals canceled nearly all scheduled surgeries and required at least one patient to be transferred to another hospital. The walkout affects four hospitals in the northern panhandle of the state, bordered by Ohio and Pennsylvania.

A similar walkout was averted in Pennsylvania when the incoming governor promised he'd make the issue a high priority. (See sidebar.)

State Fails to Act

According to an Associated Press report, last-minute talks between the surgeons and state officials failed to stop the West Virginia walkout. The orthopedic, general, and heart surgeons say the state has not done enough to address their skyrocketing medical liability insurance costs.

The state passed a bill in December 2001 guaranteeing all health care providers in the Mountain State access to liability insurance. (See "States Take Lead on Medical Malpractice Reform," *Health Care News*, January 2002.) The measure appears to have done little to improve the state's medical malpractice climate. Physicians are ceasing to practice there due to rising medical liability premiums, and trauma centers are closing at a rapid pace.

At least 18 of 19 surgeons at Wheeling Hospital took 30-day leaves of absence beginning in January, and 11 others have asked for leave from Weirton Medical Center. A spokesperson for both Ohio Valley Medical Center (OVMC) in Wheeling and Reynolds Memorial Hospital in Glen Dale said surgeons there were also taking leave. All four hospitals are keeping emergency rooms open.

"At least 18 of 19 surgeons at Wheeling Hospital took 30-day leaves of absence in January, and 11 others have asked for leave from Weirton Medical Center."

The surgeons want the state to make it more difficult to file malpractice lawsuits, a move they say would eventually lower their insurance premiums. They also want the state to pressure insurance companies and other third parties to pay a larger share of their overhead costs: not only insurance premiums, but also rent, labor costs, etc.

The West Virginia Hospital Association does not support the walkout. Hospitals say they will begin cutting shifts among nurses and surgical support staff if the surgeons don't come back.

Dr. Gregory Saracco, a general surgeon who went on leave from Wheeling Hospital and OVMC, said doctors want clear signals from legislative leaders that changes to the insurance system will not simply be *offered*, but will pass and become state law.

Most of the surgeons are insured through a special program created by lawmakers last year, and the state Board of Risk and Insurance Management recently cut rates for those policies. Nevertheless, yearly premiums remain among the highest in the country, ranging from $10,000 for dermatologists to $150,000 for orthopedic surgeons.

Saracco, 49 years old, said he had to borrow money twice last year to pay $73,000 for coverage—$40,000 for the state plan and $33,000 to a private carrier, Medical Assurance, to cover liability from previous medical cases. He expects it will cost him $100,000 to renew the annual policy.

"This is not a strike—I'm not protesting anything," Saracco said. "I'm taking time to look at other options. But if I don't get some help to offset my premium costs, I can't operate in this state."

Market Does Not Exist

The doctors in West Virginia say the problem is compounded because nearly every national insurance carrier has left the state market, driving premiums up dramatically.

Robert Zaleski, an orthopedic surgeon in Wheeling, said his annual premium went to $150,000. People have asked him why he doesn't feel badly about "abandoning" his patients. "The reason," Zaleski stated at a news conference, "is that we are taking some action is to improve the quality of care. We once had three neurosurgeons in Wheeling. Now we have none. They left because of malpractice insurance costs."

As insurance premiums have soared, doctors have been unable to pass the cost increases along to their patients, because many physicians are locked into managed-care health programs that limit their fees. A physician cannot stay in practice for very long with escalating overhead and decreasing reimbursement rates, the doctors note.

Conrad F. Meier is managing editor of Health Care News.

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Who is Dr. Merrill Matthews?

Merrill Matthews Jr., Ph.D., is a Heartland Senior Fellow specializing in health care policy and a visiting scholar with the Institute for Policy Innovation. Dr. Matthews is past president of the Health Economics Roundtable for the National Association for Business Economists, the largest trade association of business economists, and health policy advisor to the American Legislative Exchange Council, a bipartisan association of state legislators.

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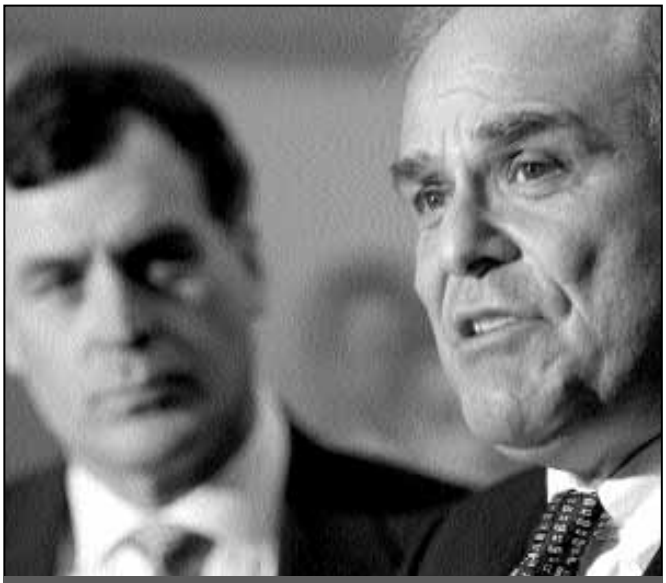

Former Pennsylvania Governor Mark Schweiker (left) joined newly elected Governor Ed Rendell to announce Rendell's plans to address the state's raging malpractice insurance crisis. The reforms are based on recommendations made by Rendell's Medical Malpractice Liability Task Force. Photo: Don Murray/Press Images

Pennsylvania Walkout Averted

Forty-two doctors in Pennsylvania agreed to call off their planned walkout after incoming Governor Ed Rendell (D) promised to fight for $220 million in aid for doctors to help pay for their malpractice insurance premiums.

The offer for aid is tentative, and Rendell must persuade a Republican-controlled legislature to accept his plan. While the new governor pledged to help pay for the premiums, he made no mention of the need for fundamental reform of medical malpractice laws in Pennsylvania.

Dr. Seth Krum, an orthopedic surgeon at Warminster Hospital in suburban Philadelphia, said he is still contemplating leaving the Keystone State for one where insurance costs would be lower. He said he has already interviewed at medical facilities in other states.

"I've had my wife in tears for months," Krum said. "I've developed a great practice. My kids are 1 and 4 years old. I don't want to leave. But this just can't continue."

Discussions of permanent reforms by the state legislature aren't likely to begin until later in the new session.

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Long-Term Care Needs Attention

KEVIN CORCORAN

Most Americans would be caught completely unprepared if they or a loved one were faced with a medical crisis that required long-term care. One out of five Americans over the age of 50 is at risk of needing long-term care in the next 12 months.

Many people have never considered their options for financing long-term care needs or the government benefits available for long-term care. When a medical catastrophe occurs, the majority of Americans are forced to self-pay for their care or rely on Medicaid to foot the bill.

Many people underestimate the cost of long-term care and do not plan adequately for the future. The cost of a year's stay in a nursing home ranges from $40,000 to $80,000, and the average stay is two-and-a-half years. Contrary to common belief, most long-term care expenses are not covered by Medicare or most employer-sponsored plans.

Medicare covers only skilled nursing care, under certain conditions, and part-time home health care. Medicaid will cover long-term care only after a person "spends down" his or her assets to qualify. Since a large share of long-term care costs is paid for by the individual or his family, without other planning, families are at risk of losing their hard-earned assets in order to provide for a loved one's long-term care needs.

Insure for the Future

One of the best ways Americans can prepare for future long-term care is through the purchase of private long-term care insurance. Such insurance offers Americans financial security as they age, as well as the ability to choose the type of care that best suits their needs.

Many types of long-term care insurance policies are available, offering a wide range of benefits for a wide range of premium prices. Depending on the policy, long-term care insurance can be used not only to finance nursing home care, but also to pay for assisted living facilities, home-based care, and other services. Premiums vary based on age, health status, and the benefits covered.

The good news is that the American public is becoming more aware of the risks associated with long-term care costs, and there has been a steady increase in sales of long-term care insurance. Improved products and the shift in public policy towards greater reliance on private dollars to finance long-term care have contributed to increasing interest in private insurance policies.

Despite these positive trends, fewer than 15 percent of all individuals over 65 and fewer than 5 percent of those under 65 have these important policies. Public policy and private efforts should be strengthened to encourage more Americans to buy private long-term care insurance.

Long-term care insurance offers benefits not only for policyholders themselves. The more people covered by long-term care policies, the lower public spending on long-term care will be in the future. Private insurance benefits will pay for long-term care instead of public dollars through the Medicaid program. Since Medicaid is one of the fastest-growing items in state budgets, it is not surprising that as many as 35 state legislatures have approved tax incentives for long-term care insurance.

In 1996, with passage of the Health Insurance Portability and Accountability Act (HIPAA), the federal government took a first step towards providing Americans with an incentive to purchase long-term care insurance by making a portion of the premium tax-deductible for individuals who buy tax-qualified plans. There also has been bipartisan support in Congress over the past few years for other long-term care measures, including an above-the-line tax deduction for insurance premiums and allowing long-term care insurance to be included in Section 125 cafeteria plans.

Long-term care insurance has benefits for consumers, their families, and state and federal governments. State legislatures and the federal government should allow the long-term care market to be vibrant and innovative. The public sector needs to continue to educate and provide incentives to consumers so they will plan appropriately for their retirement and their future long-term care needs.

Kevin Corcoran is executive vice president of the National Association of Health Underwriters.

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Scandlen AT LARGE BY GREG SCANDLEN

It's Up to Us

"Faced with confusion and complexity, which path will most Americans choose? Will we say, 'This is just too much for me, somebody please take it off my hands?' Or will we decide that given all this chaos, we need to be the masters of our own fate?"

Health care reform is going to be the biggest domestic issue in 2003. The private sector keeps developing new financing options, while financially strapped state governments are in a crisis over the rising costs of Medicaid and state employee benefits.

At the same time, the scientific community keeps developing new drugs and treatments that are full of promise, hospitals struggle to keep up with changing workforce demands, physicians are reeling from additional cuts in Medicare payments, and insurers are profoundly affected by seemingly unrelated issues such as lawsuit abuse, the drying up of reinsurance post 9/11, and depletion of their reserves by the weak stock market.

Patients, consumers, and workers may not know the details of the issues, but they are developing a growing insecurity about the whole system. It isn't just financing. They also feel confusion about what the experts tell them about medical practice. Is hormone replacement therapy good or bad? Just when we get comfortable tracking our LDL cholesterol, they tell us C-reactive protein is more important. Do childhood vaccines really cause autism? Or is it just those that contain mercury? Or is the whole idea just paranoid bunk?

The Great Choice

Some people are attracted to the imagined simplicity and security of just letting the government take care of it. They have enough to worry about. Managed care has made them comfortable with ceding health care decisions to someone else ... does it really matter if that "someone else" is a private insurer or the government?

Others recoil at the thought of concentrating more authority in government hands. They look at how the government runs other programs and see how interest groups and political patronage influence government's decisions. They see how politically difficult it is just to add a prescription drug benefit to Medicare, and how all the generous benefits of Medicaid aren't worth much if you can't find a doctor who participates in the program. They don't want Tom Delay and Nancy Pelosi defining their insurance benefits package.

Faced with confusion and complexity, which path will most Americans choose? Will we say, "This is just too much for me, somebody please take it off my hands?" Or will we decide that given all this chaos, we need to be the masters of our own fate? Will we impose our own order for the good of our own families?

The decisions we make next year and the year after will set us on a course that will have a profound effect on each one of us, our children, and our grandchildren yet to be born. There is no more important public policy issue than the future of our health care system. There is no service more personal and more intimate.

Let Health Care Compete

There is also no service more expensive. But who can say if it is *too* expensive? Who knows what the "right" amount is to spend on health care—or shoes, or peanut butter, or lawyers, or entertainment, for that matter? There is no right answer.

And there is no limit to how much money we could potentially spend on health care services. Our consumption is limited only by our priorities. Few of us would choose to spend every dollar we earn on health care services. We have other needs as well—food, shelter, clothing, education, even our desire to leave our children with an inheritance.

The way to determine the "right" amount of spending for health care is to have it compete with all the other needs and desires we have. Then we can make the judgments based on our own system of values and priorities. This requires removing the veil of subsidies, entitlements, mandates, and hidden taxes that currently hides the true cost of health care.

We who pay the taxes and insurance premiums, and we who earn our benefits as surely as we earn our wages, should be deciding how that money is spent—not some distant bureaucracy that doesn't have a clue about who we are or what is important to us. Once we regain control of the dollars, the entire health care system will rearrange itself to suit us. That is the real meaning of "patient power."

It's Up to Us

But just as the health care system affects all of us, so are we all responsible for fixing it. This is not an issue that can be left in the hands of politicians ... or employers, or doctors, or insurance companies. Reform is not a federal responsibility, nor a state, nor a private-sector one. It is *our* responsibility.

The reforms need to be all-inclusive. The private sector can do only so much before running into the restrictions of 50 years of ever-increasing regulations. Similarly, while the states have a lot of control over insurance regulation and the practice of medicine, they are also constrained by ERISA, HIPAA, Stark One and Stark Two, COBRA, and a whole bowl of alphabet soup. Even the feds can't do it by themselves. In 1996 they enacted a limited medical savings account program, only to discover many states imposed requirements that prevented MSAs from being offered.

Meanwhile, employers and physicians are in pitched battle over the Patient Bill of Rights, insurers and pharmaceutical companies are at war over direct-to-consumer advertising, nurses and hospitals fight each other over wages, working conditions, and staffing requirements. The consumer gets lost in all these parochial battles, and reform becomes a tug-of-war over which special interest will prevail.

Ultimately, we health care consumers will have to assert ourselves. The big dogs and the fat cats have dropped the ball. They cannot be trusted to do the job. We need to start calling the shots, and the best way for us to do that is to retake control over our own money.

Greg Scandlen is director of the Galen Institute's Center for Consumer Driven Health Care and assistant editor of Health Care News.

Galen Institute Launches Center for Consumer Driven Health Care

Greg Scandlen named director of new effort

Alexandria, VA—Grace-Marie Turner, president of the Galen Institute, announced on January 7 that Greg Scandlen, a long-time advocate for patient empowerment and an expert in health care financing, has joined the institute as director of its new Center for Consumer Driven Health Care.

"The time is ripe to focus clearly on the growing movement to empower consumers in health care," Turner said. "Our new Center for Consumer Driven Health Care will provide research and education on this new trend that is gaining attention in the private sector as well in public policy circles.

Scandlen most recently was a senior fellow in health policy at the Dallas-based National Center for Policy Analysis and was previously with the Cato Institute. He was founder and president of the Health Benefits Group, a consulting firm; founder and executive director of the Council for Affordable Health Insurance, a trade association of insurance companies; and director of state research at the Blue Cross Blue Shield Association.

For more information…

WWW visit the Galen Institute's Web site at **http://www.galen.org**.

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Association Group Health Insurance Sparks Controversy

MERRILL MATTHEWS

Health insurance premiums are going up by double-digit rates for the third year in a row, and some workers and employers are seeing increases of 30, 40, and even 50 percent. Not coincidentally, the number of uninsured has risen to more than 41 million Americans.

A growing number of people are finding a solution in the rapidly growing, but poorly understood, "association group" market.

An Affordable Alternative

The large majority of people under age 65 with health insurance get it through their employers. While that mechanism is convenient and usually reliable, people with employer-provided policies don't own their policies; their employers do. Employers decide what type of coverage employees will have, and when employees leave their jobs, they lose their coverage.

The self-employed and those who do not have an employer-provided health insurance option can usually buy individual health insurance policies, just as people purchase their own life and automobile insurance. While more flexible and portable than employer-provided insurance, individual health insurance has problems of its own. Individuals don't get the economies of scale that come with group coverage, and states often impose a number of regulations and restrictions on the individual market, making those policies more expensive.

Ideally, individuals should be able to get the savings that come with group coverage, along with the flexibility and personal ownership available in the individual market. That is what the association group market provides.

What Is Association Group Insurance?

Millions of Americans are members of associations. Some of those associations are job- or career-related, some are hobby-related, and some are tied to people's special interests. Many of them offer access to or group discounts on a whole range of products and services; for some, those products include health insurance.

Purchasing health insurance, as well as other products and services, through an association is a long-established and well-accepted model. Perhaps the oldest and largest of these associations is the AARP. Some 35 million people, roughly a third of whom are under age 60, pay annual dues to AARP because they believe they get value out of being a member. One of those options is Medicare supplemental insurance, which millions of AARP members purchase.

There are roughly 15,000 associations in the U.S. today, including such groups as the local Chambers of Commerce, the American Automobile Association, the National Rifle Association, and the Sierra Club. Following the AARP model, some associations have decided to offer health insurance to their members, using an established insurance company to write the policies.

Regulation by States

Critics of association group insurers contend they are not regulated by the states, as are the individual and small group health insurance markets. However, 46 states specifically authorize group health insurance offered through associations, and those states mandate the benefits that are offered.

In addition, the National Association of Insurance Commissioners (NAIC) has provided a model to guide states' oversight of the association group market. The NAIC guidelines assert:

- "The association or associations shall have at the outset a minimum of 100 persons and have been organized and maintained in good faith for purposes other than that of obtaining insurance;
- "Shall have been in active existence for at least one year;
- "And shall have a constitution and by-laws that provide that (i) the association or associations hold regular meetings ..., (ii) ... collect dues or solicit contributions from members, and (iii) the members have voting privileges and representation on the governing board and committees."

It is true many states do not regulate the association group market to the same extent they regulate the individual and small group markets. But that is precisely why insurers selling policies through associations can offer more choices at lower prices.

Large employers who provide health insurance usually self-insure under the Employee Retirement Income Security Act (ERISA), which places their plans under federal law rather than state insurance laws. A primary reason for self-funding is that those employers have more freedom to structure their plans and control the cost of coverage. About half of those who have employer-provided coverage are in self-funded plans. These plans don't escape health insurance laws, they just operate under different laws. The same can be said for most association group plans.

If the concern is that less regulation of association groups has created an unlevel playing field, putting the individual and small group insurers at a disadvantage, the solution isn't to regulate association groups more but to regulate the other markets less so they too can offer a wide range of polices at affordable prices.

Are Insurers Too Close to Associations?

Another criticism is that some associations have too close a relationship with the insurers providing the coverage.

It is probably true that some insurers have a close working relationship with the associations that sell their policies. But many associations have been working closely with their insurance provider for years. You would expect the head of AARP to have a good working relationship with the CEO of Prudential, which sells policies to AARP's seniors. And if AARP wanted to restructure some of the policies it offers, it would surely go to Prudential executives beforehand to discuss workable options and get the insurer's input.

In fact, there is nothing inherently wrong with an insurance company playing an important role in forming an association that eventually will market its policies, just as Colonial Penn did with AARP. The NAIC and many states may discourage the practice, and most insurers follow those laws and guidelines. But it is a reasonable way to create a viable group to purchase health insurance.

"Association group health insurance is a well-accepted model that already offers some 6 million Americans affordable health insurance."

One of Many Choices

Some 6 million Americans are currently insured through association groups, and more are choosing that option all the time. These people are not forced to pay additional money to join an association just to get health insurance. They choose this option.

Most states have viable individual health insurance markets, and people often have more choices at lower prices there than they get from a group policy. Thirty states have high-risk pools for those with pre-existing conditions who may not otherwise be able to obtain coverage. If consumers don't want to join an association or don't like the policies offered by associations, they are free to choose another option.

Denying consumers the association group option by eliminating or over-regulating them doesn't protect consumers, it simply denies them one option among several. This is a flawed model of consumer protection; a better model seeks to use competition and choice to make insurers more accountable to their customers.

Complaints against association groups come primarily from insurers offering other types of coverage in states where association groups do business. By offering consumers more options at affordable prices, association groups increase competition and attract people who otherwise would be forced to pay higher prices. Unfortunately, calling for increased regulation of one's competitors is an increasingly common business tactic, and consumers are invariably the losers.

Conclusion

Association group health insurance is a well-accepted model that already offers some 6 million Americans affordable health insurance. It is not an anomaly or a trick to avoid regulation: Associations for many years have offered people a wide range of products and services. The association model offers the best features of employer-provided and individual health insurance.

Offering a better product at a lower price always upsets established vendors who are used to a captive audience, but the freedom to innovate and compete for customers is the keystone of a prosperous society. Association group insurance should be part of any plan to encourage more people to be insured and to slow or stop the rise in health insurance premiums. Elected officials should resist calls to limit the ability of association groups to compete for new consumers.

Merrill Matthews is executive director of the Council or Affordable Health Insurance, a nonprofit association based in Alexandria, Virginia.

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States Use HIFA Waivers to Expand Private Insurance

NINA OWCHARENKO

Waivers granted through the Health Insurance Flexibility and Accountability (HIFA) initiative give state officials an opportunity to expand health care coverage to the uninsured and help individuals and families escape crumbling public health programs such as Medicaid. State officials should seize the opportunity to offer private health care coverage options to these populations.

Utilizing HIFA waivers will not only bring immediate benefits to those who receive coverage, but also will promote the longer-term goal of improving the efficiency and effectiveness of the nation's health care system.

The HIFA Initiative

The HIFA initiative, announced by Health and Human Services (HHS) Secretary Tommy Thompson in 2001, is based on the Medicaid and State Children's Health Insurance Program (SCHIP) Section 1115 waivers. The HIFA program gives states the flexibility to design innovative approaches to increase health care coverage for the uninsured by using existing Medicaid and SCHIP resources.

HHS guidelines and templates simplify the HIFA waiver application process for state officials and ensure priority review, so waivers do not languish in the federal bureaucracy.

While states are granted broad flexibility, the administration emphasizes several features it is looking for in waiver applications. The HIFA guidance states:

> The Administration puts a particular emphasis on broad statewide approaches that maximize private health insurance coverage options and target Medicaid and SCHIP resources to populations with income below 200 percent of the Federal poverty level.

State officials should pay particular attention to the private coverage preference: A decision simply to expand conventional public health care programs, such as Medicaid, will escalate costs to taxpayers and reduce rather than increase access to quality care for low-income individuals and families.

Progress through HIFA

HHS has approved seven HIFA demonstration waivers. While none has achieved an ideal plan, all of the states have incorporated private coverage elements in their projects.

The Illinois demonstration, for example, covers 300,000 residents with incomes at or below 185 percent of the federal poverty level (FPL). It expands coverage to parents of Medicaid and SCHIP children and strengthens its hemophilia and uninsurable programs. Under the demonstration project, some individuals will receive premium assistance to help them purchase coverage through their employer instead of receiving direct state coverage.

The Maine demonstration expands coverage to 11,500 childless adults by building on the state's private insurance premium program and utilizing employer-sponsored coverage for qualified individuals.

Oregon's demonstration expands enrollment in the state's premium assistance program for employer-based coverage and, in some cases, individual policies, to cover 60,000 residents with incomes up to 185 percent of FPL. It targets uninsured individuals, including pregnant women, low-income children, parents of Medicaid and SCHIP children, and childless adults.

New Mexico expands coverage to 40,000 adults with incomes at or below 200 percent of FPL by contracting with insurers to provide a state-designed benefit package for employers to offer their low-income, uninsured workers. It targets parents of Medicaid and SCHIP children and childless adults.

Arizona expands coverage to childless adults,

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of the movement, Claude Vorilhon, a/k/a Rael, said Clonaid and the Raelian movement are "very different" and he could not personally vouch for the accuracy of Clonaid's claims. Clonaid is a U.S.-based company established by Vorilhon in 1997. Brigitte Boisselier, president of Clonaid, is a bishop in the Raelian cult.

Complex Issue

The Food and Drug Administration (FDA), which regulates human experiments, contends its regulations forbid human cloning without prior agency permission—permission it has no intention of giving. FDA officials have launched an investigation into whether Clonaid illegally performed any of the services for "Eve's" alleged birth on U.S. soil.

At least in part because there is concern FDA's authority on the matter won't hold up in court, there is wide support in Congress for a ban on cloning for the purpose of producing babies. The United States currently has no specific law against human cloning. Observers acknowledge an outright ban would have limited reach, as U.S. citizens could still go abroad to seek cloning opportunities.

Cloning raises not only the possibility of producing babies, but also the possibility of medical breakthroughs—"therapeutic" cloning. Through cloning, researchers can manufacture embryonic stem cells—fundamental building blocks that can develop into any of the 200-plus kinds of tissue found in the human body. Such cloning, already successfully employed in animals to repair damaged nerves and organs, may hold the key to treating such human ailments as heart disease, Parkinson's, and spinal cord injuries.

Last year, the U.S. House of Representatives passed a bill, backed by President George W. Bush, banning cloning. Liberal Senator Edward Kennedy (D-Massachusetts) and conservative Orrin Hatch (R-Utah) partnered last year to advance a bill that would ban only reproductive cloning, arguing that continued research on therapeutic cloning was crucial.

Many scientists believe embryonic stem cells—"master cells" that can form any tissue in the body—may hold keys to lifesaving therapies. One way to get stem cells is to clone an embryo.

Neither side of the issue—proponents of a complete ban, and those who support research for therapeutic cloning only—garnered enough votes to pass their measures.

"Lawmakers who pushed for the therapeutic-only measure last year studiously avoided comment on the Clonaid announcement, fearing the uproar would harm efforts to keep cloning for medical research legal."

"Of course, all society—from scientists to politicians—is against human reproductive cloning," asserted Dr. Robert Lanza, medical director of Advanced Cell Technology, a biotech firm in Worcester, Massachusetts that has led the way in cloning human embryos for stem cell research. "No one wants to see 100 copies of Madonna or Michael Jordan. But it would be tragic if this outrage spills over into legitimate medical research that could cure millions of patients."

"If you allow embryo cloning in research labs because of its supposed great potential," countered Representative Dave Weldon (R-Florida), who did research in molecular genetics in graduate school, "you're going to have all these labs with all these embryos, and it will be that much easier for people like the Raelians to try to do reproductive cloning."

Senator Sam Brownback (R-Kansas) has pledged to reintroduce this session legislation for a total cloning ban. Clonaid's announcement "should serve as a chilling reminder that individuals are still trying to clone human beings," said incoming Senate Majority Leader Bill Frist (R-Tennessee), a physician who supports banning all forms of human cloning.

Lawmakers who pushed for the therapeutic-only measure last year studiously avoided comment on the Clonaid announcement, fearing the uproar would harm efforts to keep cloning for medical research legal.

Science vs. Religion

"This science offers us enormous hope," said Michael Mangiello of the Coalition for the Advancement of Medical Research, which is preparing to fight again for allowing research on therapeutic cloning to proceed.

Pro-life groups oppose embryonic stem cell research because culling those cells destroys a human embryo. The National Right to Life Committee decried "human embryo farms" in statements urging an immediate ban on such research. Conversely, the Union of Orthodox Jewish Congregations of America supports the research, arguing that a few-celled embryo in a laboratory dish doesn't deserve the same protections as a person.

Even if Congress succeeds in banning cloning, embryonic stem cells could be culled from embryos left over from fertility treatments, a point Senate Majority Leader Frist makes. In September 2002, California Governor Gray Davis signed into law a measure that requires fertility clinics to tell women they can donate their embryos to research. (See "California Defies Federal Stem Cell Policy," *Health Care News*, November 2002.)

Conrad F. Meier is managing editor of Health Care News.

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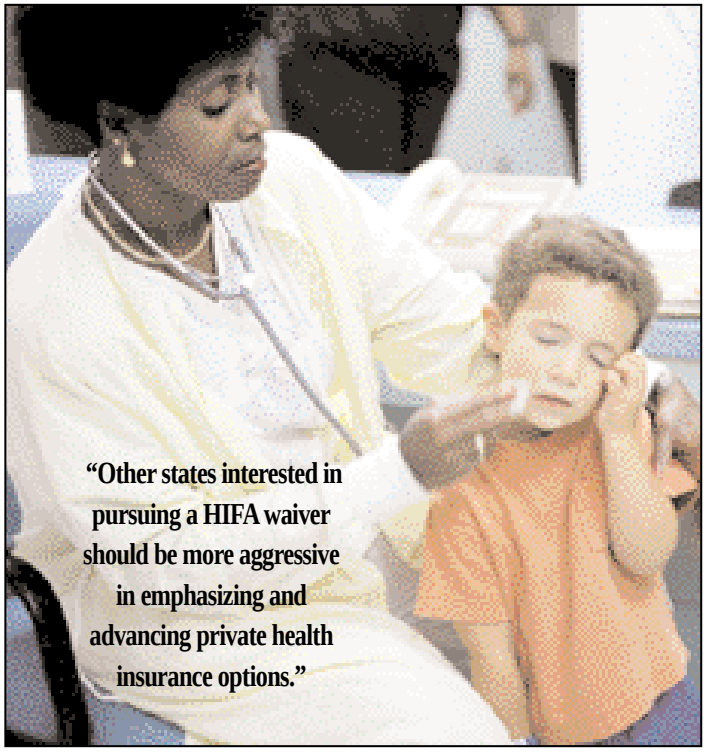
"Other states interested in pursuing a HIFA waiver should be more aggressive in emphasizing and advancing private health insurance options."

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and both Arizona and California expand coverage to parents with children enrolled in their state Medicaid or SCHIP programs and call for feasibility studies on integrating employer coverage into their proposals. HHS has indicated it will help ensure these states incorporate private coverage by offering technical assistance to them to meet this requirement.

In a two-phase demonstration, Colorado expands coverage to uninsured pregnant women with incomes up to 185 percent of FPL and to low-income children and adults. It also plans to develop an employer-based coverage component for the second-phase group.

"Waivers granted through the Health Insurance Flexibility and Accountability (HIFA) initiative give state officials an opportunity to expand health care coverage to the uninsured and help individuals and families escape crumbling public health programs ..."

What State Officials Should Do

While these waivers do coordinate with private coverage, other states interested in pursuing a HIFA waiver should be more aggressive in emphasizing and advancing private health insurance options. Specifically, they should:

- Offer existing Medicaid/SCHIP beneficiaries a premium assistance option for private health coverage. Declining access to quality care is becoming a growing problem under Medicaid. States should utilize the HIFA waiver to allow enrollees to change from state-sponsored coverage to a private coverage option of their own choosing. Mainstreaming certain Medicaid and SCHIP populations into private coverage will also help ease the obligations on state-provided coverage and improve the quality of care for the truly indigent who must receive coverage through the state.
- Allow premium assistance to be applied to all types of private coverage. States should permit individuals who receive premium assistance in lieu of state coverage to apply that assistance to their coverage of choice. While employer-sponsored coverage may be a likely choice, it should not be the only or required option. States should use the HIFA waiver to promote choice and give individuals the freedom to use premium assistance for all types of private coverage, including policies purchased on the individual market.

Conclusion

The Bush administration's innovative HIFA initiative gives states the flexibility to expand coverage to the uninsured by integrating private coverage options with traditional Medicaid and SCHIP programs. States can also use this opportunity to strengthen those programs.

Building on the progress achieved through welfare reform, states can mainstream individuals and families out of poorly performing public health programs and help them secure private coverage. Such efforts would immediately benefit the individuals and families directly involved, and would also be compatible with the longer-term goal of giving low-income individuals and families federal assistance to purchase private health care coverage.

Nina Owcharenko is a policy analyst at The Heritage Foundation. Derek Hunter, research assistant at The Heritage Foundation, contributed to this report, originally published by The Heritage Foundation on December 13, 2002.

Congress Should Make MSAs Permanent

KEVIN C. WAYCASTER

The Medical Savings Account (MSA) pilot project, created by provisions in the Health Insurance Portability and Accountability Act of 1996 (HIPAA), is scheduled to expire on December 31, 2003. The 108th Congress is expected to consider making the program permanent and removing current restrictions that limit the number of Americans who can take advantage of MSA benefits.

In October 2002, the Internal Revenue Service reported that 73 percent of Americans who purchased a Medical Savings Account in 2001 had been previously uninsured. Clearly, MSAs have provided the uninsured with a viable option by which to obtain health insurance. The U.S. uninsured population currently stands at more than 40 million, suggesting expansion of the program should be a high priority for Congress this session.

"In October 2002, the Internal Revenue Service reported that 73 percent of Americans who purchased a Medical Savings Account in 2001 had been previously uninsured."

What Is an MSA?

A Medical Savings Account is a fully portable savings account funded with pre-tax dollars to pay health care expenses. By law, it must be paired with a high-deductible health insurance policy covering catastrophic losses. The MSA pilot project allows only small employers and self-employed individuals to purchase MSA plans. Funding for the account itself can come from the employer or from the employee, but not from both.

MSAs give patients substantial control over their health care spending, ideally making them more responsible consumers of health care services. The goal is to discourage small claims that are costly to process and frivolous expenditures that have helped fuel inflation in the health care industry.

Need to "Reverse Course"

In his article, "How to Cure Health Care," published in the Winter 2001 issue of *Public Interest*, Nobel Laureate economist Milton Friedman observed, "The high cost and inequitable character of our medical care system is the direct result of our steady movement toward reliance on third-party payment. A cure requires reversing course, reprivatizing medical care by eliminating most third-party payment, and restoring the role of insurance to providing protection against major medical catastrophes."

Most medical expenses today are paid not by individual patients themselves, but by third parties: the government, through such programs as Medicaid and Medicare, or insurance companies. Most health insurance is provided by employers, further insulating consumers from the costs of their decisions. Patients, therefore, have little incentive to shop for lower prices and make careful decisions about the medical services they seek.

If we were similarly insulated against the cost of our meal choices in a restaurant, it's easy to see what would happen. Presented with two meal options—a hamburger platter or lobster-and-steak combo—we'd be more likely to choose the expensive meal if "the government" or an insurance company would pick up the tab for us. By contrast, if we're paying out of our own pocket, even if that payment is coming from a tax-free savings account provided by an employer but legally our property, the less-expensive hamburger platter might be good enough. Alternatively, if we really wanted that surf-and-turf combo, we might at least call around to three or four restaurants to find the best deal.

This simple truth lends credibility to the argument that escalating health care costs are driven, at least in part, by the current tax code that rewards those who have low-deductible comprehensive health insurance policies, to the detriment of the self-insured and uninsured.

Permanent MSA Law Needed

Since 1996, HIPAA has been a permanent fixture in the world of health care compliance. But some provisions of the act—specifically the MSA provisions—have not been made permanent. Congress still has not removed the initial restrictions placed on MSAs in the 1996 compromise that created HIPAA.

The sunsetting of the MSA pilot project at the end of the year presents the 108th Congress with an important opportunity. Rather than relegate MSAs to "bargaining chip" status by keeping the program temporary and limited, Congress ought to approve a permanent and unrestricted program. By doing so, Congress can show the interests of millions of uninsured Americans trump politics.

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A Health Care Reform Agenda

PART 1 OF 2

BY JOHN MCCLAUGHRY

John McClaughry is president of the Ethan Allen Institute, a nonprofit research and education organization based in Vermont. This Agenda was produced with financial support and input from the members of State Policy Network, a national support organization for free-market think tanks.

Reprinted below are the group's recommendations for changes to be made at the *federal* level to improve health care in the United States. In the second installment of this two-part series, which will appear in the March 2003 issue, we will present the group's recommendations for *state*-level reforms.

For more information…

WWW on the Ethan Allen Institute, visit its Web site at **http://www.ethanallen.org** or contact John McClaughry by email at **eai@ethanallen.org**. For more information on State Policy Network, visit its Web site at **http://www.spn.org**.

Desirable Federal Changes

1. Congress should enact a federal income tax credit for health care expenses.

Consumers, especially those who do not enjoy employer-provided coverage, often lack the means to obtain affordable health insurance. That can be remedied by a federal income tax credit for the purchase of insurance. The credit should be refundable (paid in cash if the credit amount exceeds the consumer's tax liability); advanceable (made accessible to taxpayers in advance of income tax filing); and inversely proportional to income.

President Bush's proposal (2002) for a sliding scale credit up to $3,000 for a family of four would dramatically reduce the number of families now without insurance by making it possible for them to afford coverage in a competitive marketplace. It would also dramatically reduce any need for states to expand Medicaid into ever-higher income groups, and reduce state expenditures for that purpose.

2. Congress should encourage individuals and families to create tax-favored Medical Savings Accounts.

Tax-deductible MSAs are available under federal tax law for the self-employed and employees in firms with no more than 50 employees. MSAs are usually coupled with a relatively inexpensive high-deductible major medical insurance policy. Individuals and families can use funds deposited in an MSA to pay for such routine expenses as physical examinations, immunizations, vision care, prescription drugs, dental work, and other medical costs incurred before the insurance policy's annual deductible is reached.

MSAs give families a financial incentive to use preventive care to maintain wellness. As balances in their MSAs increase, they can switch to higher deductible coverage and pay lower premiums without giving up major medical protection. In addition, many doctors will give up to a 50 percent discount for patients who pay for treatment at the time of service, a practice that an MSA makes easy.

Unfortunately, the restrictions enacted by Congress in 1996 have discouraged MSA use. The federal law should be changed to allow any individual or family to create an MSA regardless of income or employment status; allow employee and third-party contributions; allow carryover of unspent balances to a new year; allow more flexibility in the policy deductible; and make the authorizing legislation permanent.

Similar to MSAs are health care benefits provided by a tax-favored employer-funded Flexible Spending Account ("cafeteria plan"). Through their FSA employees can purchase a number of benefits, including health coverage. However, unspent FSA balances cannot be rolled over into a succeeding year; they revert to the employer. Setting up an FSA plan to meet the detailed IRS requirements involves considerable expertise and cost.

Internal Revenue Service Revenue Ruling 2002-41 in June 2002 authorized a new product similar to an MSA but without some of the MSA restrictions. The ruling allows employers to deduct contributions to employer-owned "Health Reimbursement Arrangements" (HRAs), from which employees are reimbursed for their qualified health expenses. The year-end balance in an HRA can carry over to the ensuing year.

The federal government should rationalize these three similar plans into one unambiguous, simple, flexible plan, readily available to all persons regardless of income or employment status, and allowing carryover of unspent balances for future use for the approved purposes. The operative principle is that all persons in the workforce ought to enjoy tax equity, whether self-employed, retired, employed by a company that provides health benefits, or employed by a company that does not.

3. Congress should enact legislation to create a national legal framework for individuals and families to enroll in Association Health Plans and Individual Membership Association plans.

AHPs are health insurance plans created for associations of small businesses in a number of states. They would be regulated for financial solvency and truthful representation under one federal law instead of the diverse benefit-laden insurance laws of the several states. Each plan would offer various coverage choices to members. AHPs could purchase insurance for their members or be self-funded (liable for payment of claims from their own reserves, bolstered by stop loss insurance to protect against catastrophic claims.)

IMAs would be similar interstate associations created to insure individuals who are members of professional societies, churches, fraternal societies, etc. Both of these multi-state plans would expand affordable choices for consumers and avoid costly state mandates.

4. Congress should enact legislation to override state laws to allow employers to purchase a variety of insurance polices for employees, rather than requiring one group policy covering all employees.

Sec. 106 of the Internal Revenue Code allows employees to choose their health insurance from different carriers, a practice known as "list billing," and still retain the tax exclusion for the money their employers spend on the insurance. However, most states have passed legislation prohibiting employers from doing so. By ending this practice, employers could allocate a defined contribution for each employee, who then selects a suitable policy from a menu of choices. If the policy costs more than the employer's defined contribution, the employee pays the difference. The employer serves as the intermediary to manage employee enrollment, bill employees for their share, and remit payments to insurers.

The key to making this policy work is to allow insurers to underwrite each applicant. Those who are medically uninsurable at the time of application should be allowed to enter the state's high-risk pool, with the employer's contribution directed to the pool.

5. The federal government should make block grants to the states in lieu of other funding.

Block grants should be used in place of complex Medicaid, SCHIP (state children health insurance program), and DSH (disproportionate share hospital) payments. This would allow states maximum flexibility to design their own programs to assist lower income families, just as the landmark TANF welfare reform act of 1996 did for income support.

6. Congress should pay health care providers the full cost of services provided to Medicare patients.

Cost accounting for health care services is admittedly complicated and involves numerous arbitrary cost allocations. However, it is widely acknowledged that both Medicare and Medicaid reimbursements to providers are well below the market cost of services rendered. This underpayment requires providers to shift costs to other patients who have private-sector insurance. This in turn results in a premium cost increase—in effect an unlegislated tax on private health insurance to subsidize government health care programs.

In addition, chronic and severe underpayment by government programs, coupled with complicated, demanding, and often arbitrary reporting requirements, has become an increasing incentive for health care professionals to simply refuse to treat patients in those programs. Higher levels of government reimbursement to providers should be coupled with substantial simplification of reporting requirements, a reduction in aggressive prosecution for relatively minor and unintentional technical violations, and an end to completely unreasonable "health crime" penalties.

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7. Congress should expand Medicare+Choice options within the Medicare program.

Allowing more seniors to apply an average Medicare payment to the purchase of private insurance would give them a range of choices and expand insurance markets.

8. Congress should enact a Medicare prescription drug benefit.

Such a benefit should be designed as an income-based subsidy deposited in the beneficiary's prescription drug security account, coupled with private insurance for extraordinary costs. The availability of such a benefit would directly reduce state Medicaid costs with respect to dual-eligible patients (principally poor and disabled seniors who benefit from both programs) and beneficiaries of state-financed drug purchase assistance programs. Federal block grants to the states would be adjusted to reflect such reduced spending.

9. Congress should enact medical malpractice reform.

Soaring malpractice judgment awards have seriously raised the costs of medical care (especially for obstetrics-gynecology) and insurance premium costs in many states, and have even driven professionals out of medicine. Corrective federal legislation would include imposing a limit on non-economic and punitive damages and attorney's fees; ending joint and several liability (where every contributory party is at risk for the entire judgment, regardless of its contribution to the injury); adopting a high tort standard of "gross and willful negligence" in medical malpractice cases, in place of a standard that allows plaintiff victories where the doctor makes a well-informed, rational judgment call that leads to harmful results (especially important for charitable and humanitarian care); and (as in Nebraska) assigning punitive damage awards to state high-risk pools, health information system support, or other public programs instead of to the plaintiff's attorney. (These steps could also be taken in individual states, but usually fail due to concentrated opposition from the trial bar.)

10. Congress should cap and eventually phase out sec. 105 income tax deductions for employer-sponsored health insurance plans.

This would leave employers to organize a menu of plans, provide information, aggregate employee portfolio groups, and perform administrative duties, but not pay for premiums. Employees would earn higher wages and salaries, make their choice of plans, and pay for the premiums out of their MSAs or other similar tax-favored accounts. Depending on their income levels, employees would have a choice of tax deductibility or a tax credit. This would allow the tax deductibility and credit to vest with the individual employee, and remove the regressive deductibility of employer health care contributions for high-income employees. Employees would own their plans. The plans would be fully portable when the employee changed employers or retired. Balances in the MSA could be assigned to others via gift or bequest.

This proposal is obviously a very fundamental change that will not come easily, as employer-provided health insurance has for 60 years been a major feature of American life. It should, however, be discussed in connection with any comprehensive program of federal tax reform.

Political Parties Take Opposing Sides in Health Care Debate

ROBERT GOLDBERG

The debate between Democrats and Republicans over health care issues in 2003 promises to be more productive than it has been in quite some time.

Republicans may finally show some interest in a topic that is near the top of voters' lists of concerns, though early mishaps suggest they may once again blow the chance to lead. Democrats will update their version of the Fear Factor—emitting visions of people who are sick, dying, or dead without health care coverage—and offer Americans the opportunity to get medical coverage through Medicaid, mandates, and higher taxes.

DEMOCRATS OFFER BIGGER GOVERNMENT

The Democrat proposal—shaped largely by its liberal wing with the help of Families USA—bumps up against the state Medicaid programs already facing large deficits and comprising the largest portion of state budgets.

There are already 37 million adults and children served by Medicaid each year, and Democrats want to add 40 million more. The idea of having nearly half of all Americans enrolled in government-run health programs (if you include 35 million senior citizens receiving Medicare) might excite Families USA and others, but it's highly unlikely states will want to take on the new burden. Medicaid spending is increasing at twice the rate of overall state government spending.

The Democrats will respond to state concerns by calling for higher taxes or mandates requiring private-sector firms either to cover their employees or pay into Medicaid. The other "choice" will be "allowing" the uninsured to buy into Medicaid with their own money, federal subsidies, or some combination of the two.

But states are already planning ways to scale back Medicaid to save money, including limits on who is eligible, cuts in fees paid to doctors, restrictions on access to new drugs, and reduced services to disabled children and the mentally ill.

Unlike people with private health insurance, Medicaid recipients must fight with other interest groups for scarce public dollars. Indeed, over the years, health services under Medicaid have taken on a Hobbesian form: nasty, brutish, and short-lived.

As Medicaid and the state-run CHIP program have become the insurers of first resort, they have crowded out appropriate care for the poor and disabled, placing inordinate demands on the public treasury. Now, real and ugly rationing is taking place at the very moment Democrats want to shove millions more Americans into these programs.

The right response is to make a wide range of health care plans more affordable and available, not to prop up Medicaid or scapegoat the usual suspect, the pharmaceutical industry. But Democrats will blame Medicaid's woes on rising drug costs, ignoring the facts that (a) prescription drugs represent only 9 percent of federal Medicaid costs and 12 percent of total Medicaid program spending and (b) drugs are far less expensive than the alternative, in many cases hospitalization.

REPUBLICANS SEND MIXED SIGNALS

Since battling the Clinton health plan in 1993, Republicans have been largely bereft of any real conviction about health care issues. Rather, the past Republican accomplishments—including the expansion of Medicaid and the creation of the State Children's Health Insurance Program—can best be characterized as Ted Kennedy with half the calories.

Today, President George W. Bush appears ready to lead congressional Republicans in a much different direction: giving Americans the money and tax breaks they need to choose their own health care and preserve their relationships with doctors and hospitals they trust.

But poor political habits are difficult to break. Tom Scully, director of the Centers for Medicare and Medicaid Services, has all but handed the Democrats their talking points by telling hospital executives the way for states to control Medicaid spending is to take on the drug companies. "Not many states have the courage to take this on," Scully said. "I love the drug companies, but I think it's insane (for Medicaid) to charge a $1 to $3 co-payment to buy Celebrex and Vioxx. ... Celebrex and Vioxx are no better than Motrin. It's a joke."

"Since battling the Clinton health plan in 1993, Republicans have been largely bereft of any real conviction about health care issues. ... Today, President George W. Bush appears ready to lead congressional Republicans in a much different direction ..."

What's a joke is that the bleeding ulcers and stomach problems associated with long-term Motrin use used to be one of the primary reasons the elderly were admitted to the hospital, and Scully apparently doesn't know it. It's also a joke he doesn't realize many of the "courageous" actions states are using to control drug spending—such as limiting access to new drugs for schizophrenia—are causing untold unnecessary suffering and driving up total Medicaid expenditures. Scully's words and ignorance will come back to hurt Republicans as they seek to wage and win a principled fight on health care.

Medicaid is falling apart because it is a government-run health plan—not because of prescription drug costs. The sooner Republicans and moderate Democrats find and stick to that message, the better it will be for Americans in search of better health care.

Robert Goldberg is senior fellow and director of the Center for Medical Progress at the Manhattan Institute for Policy Research.

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U.S. Spent $1.4 Trillion on Health Care in 2001

CONRAD F. MEIER

Americans spent an unprecedented $1.42 trillion on health care in 2001, an average of $5,035 per person, according to a federal report released jointly by the Department of Health and Human Services (HHS) and the Centers for Medicare and Medicaid Services (CMS).

Total health care spending reached an all-time record and grew at the fastest rate in a decade. Spending on health care was up 8.7 percent from 2000, a year-to-year jump not seen since 1990. While economists have reported increases in health care spending every year since 1970, recent trends have analysts worried the increases are too rapid in a sagging U.S. economy.

Fourteen Percent of GDP

The report noted spending on health care accounted for 14.1 percent of U.S. gross domestic product in 2001, a 0.8 percent rise from the year before. That increase comes after eight years during which health care's share of GDP was falling, largely due to managed care practices aimed at controlling costs.

Katherine Levit, director of the National Health Statistics Group at CMS, said analysts had not seen such a spike in spending since 1990, when similarly increasing costs led to the rapid rise of HMOs and other types of managed care. Levit, who supervised production of the report, told Reuters, "We probably should be on the lookout for some policy changes or some private sector initiatives that put the brakes on spending growth."

Published in the January/February 2003 issue of *Health Affairs*, the spending report found the primary reason for the increase in health spending was increased utilization of medical goods and services by the burgeoning senior citizen population. The economic recession, exacerbated by the September 11 attacks, created added pressure on medical care spending.

Levit explained to the *New York Times*, "There was some increase in prices, but it was not as large as the increase in quantity. For example, more diagnostic tests were ordered, more days were spent in hospitals, more outpatient services were provided, and there was greater use of technology."

CMS estimates health care spending could reach $1.7 trillion this year. The continued spending increase will be driven by an undeniable demographic trend: 75 million aging baby-boomers are demanding more freedom in medical care choices while demanding high-quality health care outcomes.

Political Reactions

Health policy experts at the Galen Institute, Heritage Foundation, Brookings Institution, and other think-tanks agree that while high and rising spending levels are not per se evidence of a public policy problem, there is evidence that flawed government programs and regulations account for a substantial portion of current spending. The latest figures add a sense of urgency and purpose to the 108th Congress's health policy agenda as well as state budget deliberations. Major reforms are on the table as lawmakers debate how best to stem rapidly rising costs in Medicare, Medicaid, and other programs.

Some important policy changes have already begun to materialize. With states facing a total of $50 billion in budget deficits and declining tax revenues, many governors have already pared benefits or are restricting enrollment in Medicaid and other state-run health programs, not only for their low-income populations but also for state employees enrolled in state-run health care plans.

Senator Charles E. Grassley (R-Iowa), chair of the Senate Finance Committee, has said he favors offering states short-term grants to help them fund their Medicaid programs. Meanwhile, a Republican congressional aide, requesting anonymity, said lawmakers would likely go beyond short-term fixes and consider structural reforms to make the program more efficient.

According to the GOP aide, Republicans will move this year to enact laws that help states control their spending on prescription drugs and long-term care for elderly and disabled Medicaid patients. "It's not sufficient to say that we simply need to throw money at Medicaid to fix its problems," the aide said.

"If this isn't an argument for Medicare and Medicaid reform, I don't know what is," said Tom Scully, administrator for CMS. But liberal Representative Pete Stark (D-California) disagreed, noting "Medicare increased payments to providers and still managed to keep overall spending growth to 7.8 percent in 2001. Meanwhile, private insurance premiums went up 10.5 percent. I cannot understand why Republicans continue to devise plans for turning Medicare over to private health insurers and HMOs."

Many experts believe private-sector insurance premiums are rising due to cost-shifting by providers, who are trying to recover losses incurred from treating Medicaid and Medicare patients.

The new report makes no attempt to quantify the impact on spending of 1,500 unfunded health benefit mandates passed by state and federal government agencies. Nor does it estimate the effect of the growing regulatory burden on the health care industry, including the extensive compliance regulations embodied in the Health Insurance Portability and Accountability Act of 1996.

Conrad F. Meier is managing editor of Health Care News.

> **"Americans spent ... on average $5,035 per person [in 2001]. Spending on health care was up 8.7 percent from 2000, a year-to-year jump not seen since 1990. ... [S]pending on health care accounted for 14.1 percent of U.S. gross domestic product in 2001 ..."**

What the Study Found

Hospital Care
Hospital spending in 2001 reached more than **$451 billion**. Between 1999 and 2000, the quantity of services used per patient increased by 2.2 percent; between 2000 and 2001, the rate of increase was 4.2 percent. Spending on hospital care accounted for 30 percent of the overall spending increase in 2001.

Physicians and Clinical Services
Spending on physicians and clinical services increased 8.6 percent to **$314 billion** in 2001. The increase was similar to trends in the early 1990s. Increases in the use of high-tech imaging procedures and physician visits are other reasons for the spending increase.

Medicare
Medicare spending increased 7.8 percent in 2001, to **$242 billion**, versus a 6 percent increase in 2000. Medicare spending on managed care plans fell in 2001, as some plans withdrew from the program or limited their participation. For example, a 10 percent decrease in Medicare+Choice enrollment contributed to a 3.8 percent drop in capitated payments.

Medicaid
Spending on Medicaid ballooned 10.8 percent in 2001 to **$224.3 billion**, the sharpest increase since 1993. This was driven partly by the economic recession, which helped increase enrollment due to job loss. Further, increased use of Medicaid's upper payment limit, the so-called "Medicaid loophole," encouraged states to liberalize eligibility requirements, contributing to the significant growth.

Prescription Drugs
Spending on prescription drugs increased more rapidly than spending on other categories of health services in 2001, up 15.7 percent to **$140.6 billion**. This represents the first time drug spending surpassed expenses for nursing homes and home health care combined. The rate of increase was slower than in previous years.

Source: Katharine Levit et al., "Trends in U.S. Health Care Spending, 2001," Health Affairs, *Volume 22, No. 1, January/February 2003.*

ITEM	1980	1988	1990	1993	1994	1995	1996	1997	1998	1999	2000	2001
	Amount in Billions											
National Health Expenditures	$245.8	$558.1	$696.0	$888.1	$937.2	$990.1	$1,039.4	$1,092.7	$1,150.0	$1,219.7	$1,310.0	$1,424.5
Private	140.9	331.7	413.5	497.7	509.8	532.5	557.5	589.2	628.4	669.7	718.7	777.9
Public	104.8	226.4	282.5	390.4	427.3	457.7	481.9	503.6	521.6	550.0	591.3	646.7
Federal	71.3	154.1	192.7	274.4	298.8	323.5	344.2	360.2	368.7	386.2	415.1	454.8
State and Local	33.5	72.3	89.8	116.0	128.5	134.2	137.7	143.4	152.9	163.8	176.2	191.8
U.S. Population	230	249	254	263	265	268	270	273	275	278	280	283
	Amount in Billions											
Gross Domestic Product2	$2,796	$5,108	$5,803	$6,642	$7,054	$7,401	$7,813	$8,318	$8,782	$9,274	$9,825	$10,082
	Per Capita Amount											
National Health Expenditures	$1,067	$2,243	$2,738	$3,381	$3,534	$3,697	$3,847	$4,007	$4,178	$4,392	$4,672	$5,035
Private	612	1,333	1,627	1,895	1,922	1,988	2,063	2,160	2,283	2,411	2,563	2,749
Public	455	910	1,111	1,486	1,611	1,709	1,784	1,846	1,895	1,980	2,109	2,286
Federal	310	619	758	1,045	1,127	1,208	1,274	1,321	1,340	1,391	1,481	1,608
State and Local	146	290	353	442	484	501	510	526	555	590	628	678

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STATES continued from page 1

ance state budgets will require tough decisions by governors and state legislators.

Forty-four states will consider measures to control Medicaid costs, including freezing or reducing eligibility, benefits, and/or reimbursement rates, according to the recent Health Policy Tracking Service Survey conducted by NCSL.

Massachusetts has already taken such steps. Up to 50,000 people lost Medicaid eligibility at the beginning of the year, and thousands more had their benefits cut. Massachusetts House Speaker Thomas Finneran said such steps were necessary because soaring Medicaid costs could soon "bankrupt" the state.

But Medicaid cut-backs can be a double-edged sword. During an economic downturn—when state revenues fall and policymakers might consider Medicaid cuts to balance budgets—more workers can lose the health insurance coverage they received through their employers. If state actions deny Medicaid eligibility to those individuals or limit the benefits available to them, states compound the problem of lack of access to care. Overall health care spending might increase because uninsured patients must rely on expensive emergency rooms for treatment.

Raising Taxes

Some states are considering tax increases to pay for Medicaid and other public health initiatives. This move is unpopular with taxpayers in many, but not all, parts of the United States. Voters in Los Angeles County voted last year to raise their own property taxes to keep hospitals open and prevent a collapse of the local public health system. Voters in Arizona passed a ballot measure to double the state's cigarette tax and dedicate the resulting $150 million for trauma centers.

Raising taxes, like cutting eligibility for Medicaid, can aggravate rather than solve the access problems of the poor. High and rising taxes relative to other states can result in lower rates of income and employment growth. Slower economic growth means fewer people are able to afford to buy private insurance or have employer-provided coverage.

Given recent trends in health care spending, it is unlikely that states can raise taxes fast enough to keep up. Higher taxes, then, are at best a partial and temporary solution to a larger long-term problem.

Disease Management

Another strategy taken by states is to develop disease management programs in Medicaid. Such programs contain costs for the chronically ill by taking a comprehensive view of a patient or a disease to determine the best course of treatment.

The conventional division of roles in the health care services industries can lead care providers to focus on only one disease even though a patient has multiple diseases, or one type of intervention, e.g. surgery, because that is covered by insurance, rather than a prescription drug that might make surgery unnecessary but which is not covered by insurance. Disease management programs can reduce costs as well as improve care. In some cases, doctors can reduce the number of prescriptions a patient is taking, thereby reducing potentially life-endangering drug interactions. In others, managing a chronic condition such as asthma can reduce the incidence of other painful and much more costly health problems.

Eli Lilly reports it has agreed to fund an 18-month disease management demonstration project being launched by Colorado's Department of Health Care Policy and Financing. The company's efforts will focus on the management of Medicaid patients with diabetes and Medicaid patients suffering from both schizophrenia and additional medical conditions. The Centers for Medicare and Medicaid Services is beginning a four-year study, called the Medicare Coordinated Care Demonstration project, to test whether combined disease and case management programs can improve clinical outcomes, satisfaction, quality of life, and cost outcomes for beneficiaries with multiple chronic conditions.

"Rather than raise taxes or cut benefits, states could follow the lead of private-sector employers by moving their Medicaid programs in the direction of defined contributions."

More than 20 states are now engaged in developing and implementing Medicaid disease management programs, according to AcademyHealth, a Washington DC-based research group. In states that have adopted such programs, early indicators show quality of care has improved through better collaboration among a patient's many physicians and care providers. But only minimal cost savings have been realized.

Defined Benefits Fuel Spending

As a defined-benefit program, Medicaid pays for a wide range of defined services regardless of the cost, giving patients an incentive to use all of the services to which they are entitled ... even if they don't especially need them. In Oklahoma, for example, Medicaid pays for at least two outpatient visits to a primary care provider per month for some beneficiaries; other beneficiaries get unlimited visits to primary care providers and specialists. Medicaid provides free transportation for medical care in Oklahoma, for emergencies and non-emergencies alike. In fiscal year 2001, nearly 39,000 Medicaid clients made some 260,000 trips, at a cost of more than $22 per trip.

"Taxpayers are footing the bill for better coverage than they are willing or able to buy for themselves," said John R. La Plante, a contributor to the journal *Perspective*, published by the Oklahoma Council of Public Affairs.

Medicaid's funding formula exacerbates the problem. Each state receives a different federal matching rate based on the per-capita income of its residents. Because the federal match is as high as 77 percent in some states, politicians decide it is a good idea to expand their programs to optional populations to qualify for more federal funding. But even with the federal match, states have to pay a sizable share of the cost, between 23 and 50 percent of total Medicaid expenditures. The cost of expanding Medicaid can add up quickly ... and once in place they are politically difficult to repeal.

Market-based Reforms

Rather than raise taxes or cut benefits, states could follow the lead of private-sector employers by moving their Medicaid programs in the direction of defined contributions. Each beneficiary would get a voucher worth a specific dollar amount, and then could use that voucher to choose, from a range of state-approved health plans, the coverage that best fits their individual needs. As a model, states should look to the Federal Employees Health Benefits Program, which currently provides nine million federal employees with a choice of 188 private health plans.

Vermont took a step in this direction last year. The legislature authorized a demonstration project that would allow some beneficiaries to purchase private health insurance policies with the funds they otherwise would be eligible for through the traditional Medicaid program. The state would cover all or some portion of the insurance premiums, based on a beneficiary's income, and beneficiaries would also receive vouchers for out-of-pocket costs. The Vermont plan will go forward if funding is appropriated this year.

Seven other states have taken advantage of a new waiver initiative introduced by the Bush administration to expand coverage to the uninsured through private health coverage options. (See "States Use HIFA Waivers to Expand Private Insurance," page 8.) Called the Health Insurance Flexibility and Accountability initiative, the measure gives states the flexibility to use existing Medicaid resources to cover low-income uninsured populations. The HIFA waiver initiative could mark the beginning of a movement toward a defined contribution structure for Medicaid that may well allow states to control Medicaid costs.

A third market-based reform is to establish or expand existing high-risk pools for the difficult-to-insure. Such pools currently operate in 30 states and provide private insurance to more than 100,000 people. The Trade Adjustment Act of August 2002 provided states with $100,000 in federal aid for high-risk pools.

Market-based reforms, by addressing flaws in the current funding and benefits structure of Medicaid, give states a way to balance their state budgets while ensuring those most in need of government-funded health care will receive it.

Joe Moser is a health policy analyst at the Galen Institute, a not-for-profit public policy research organization based in Alexandria, Virginia. The views expressed here do not necessarily reflect the views of the Galen Institute.

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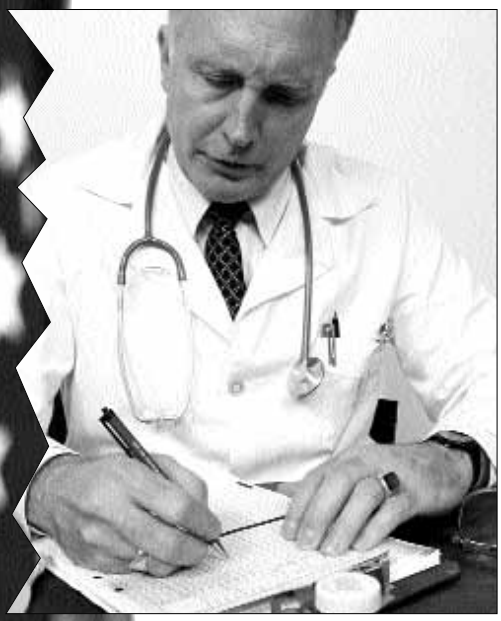
State Legislative UPDATE

COMPILED AND EDITED BY CONRAD F. MEIER

A MONTHLY REVIEW OF STATE LEGISLATIVE ACTIVITY

Managing Editor's Note:
With this issue, *Health Care News* is expanding its coverage of state-based health care news. If you have news to share regarding legislative, political, legal, and business developments in your state's health care arena, please contact me at **meier@heartland.org**.



ARIZONA

Illegal Immigrants at Hospitals

Even though U.S. immigration officials are making an effort to limit the number of illegal immigrants who enter the country from Mexico in order to receive uncompensated medical care, there is no evidence the effort is working.

During 2001 Tucson Medical Center (TMC) treated 25 illegal immigrant patients who received medical waivers, or "humanitarian parole," at the border for an uncompensated medical care cost of $1.5 million. In the first nine months of 2002, the hospital had already treated 23 cross-border patients at a cost of $1.5 million. Year-end figures were not available.

U.S. hospitals along the border have donated medical equipment to Mexican hospitals in order to remedy the problem by improving health care in Mexico. However, Mexican customs officials recently have not permitted shipments of the donated equipment to reach hospitals needing up-to-date equipment.

Dr. Cecilia Rosales, head of the Arizona Office of Border Health, told the *Arizona Daily Star*, "A lot of it has to do with President Fox's initiative to quell corruption. Intentions are good; it's just that it sort of impedes our efforts to improve the hospitals across the border."

Robert Guerrero, the market administrator for cross-border patients at TMC, said hospitals do not necessarily object to providing care to those with medical waivers; they simply want to be paid for it. He added, "It's the federal government that allows them in, and it's the federal government that requires us to treat them. But the federal government does not subsidize the cost."

Arizona Daily Star
December 16, 2002

COLORADO

Funding Rural Health Care

According to the *Denver Post*, the state legislature has developed a new plan under which millions of dollars would go to smaller hospitals and medical centers in Colorado.

The Colorado Department of Health Care Policy and Finance on December 17, 2002 suggested the legislature's Joint Budget Committee change the formula determining how much hospitals receive for treating low-income and uninsured patients.

University of Colorado Hospital, which treats the second-highest number of low-income patients in the state, and Denver Health Medical Center, which provides the most indigent care in the state, could lose hundreds of thousands of dollars per year. Denver-based Children's Hospital could lose up to $3 million.

Using the revised formula, those funds would be shifted to smaller, rural facilities. "It's not a windfall," said C.W. Smith, president of Parkview Medical Center in Pueblo. "We're not going to be adding a bunch of new clinics or anything with a million more dollars, but it's something."

The additional money is unlikely to be enough to expand services or facilities, but it is seen as positive acknowledgement that the problem of the uninsured is not limited to metropolitan areas. Smith says, "All it will do is keep our head above water."

According to figures from the Centers for Medicare and Medicaid, larger hospitals have been receiving a reimbursement rate of between 60 and 120 percent of the cost of treating indigent patients, while smaller facilities were reimbursed about 30 percent of the cost of care.

Denver Post
December 20, 2002

KANSAS

Minority Health Care Disparities

Minority residents in Kansas are less healthy and have higher rates of chronic diseases than do their white counterparts, according to a recent study conducted by the Center for Advanced Social Research at the University of Missouri-Columbia. The study, funded by the Kansas Health Foundation and the Robert Wood Johnson Foundation, was released at the "Minority Health Disparities in Kansas" summit held December 12, 2002.

The study looked at minority communities in Wichita, Garden City, and Kansas City and found:

- Infant mortality among African-Americans is double the statewide average.
- African-American men have the highest rates of prostate, lung, and colorectal cancer in the state.
- While African-Americans represent fewer than 8 percent of the state's population, they account for almost 18 percent of the diagnosed AIDS cases in Kansas.
- Thirty percent of African-Americans and 35 percent of American Indians have high blood pressure, and they die from coronary heart disease at a higher rate than the rest of the population; Hispanics, however, have a much lower rate of coronary heart disease.
- The cancer death rate for African-Americans is 28 percent higher than that of the state's general population.
- Only 67 percent of Hispanic women receive prenatal care in the first trimesters of their pregnancies, compared to 86 percent of the state's general population.
- Asian and Pacific Island women are 16 percent less likely than other women in the state to receive Pap smears.

According to the study, minorities often experience language barriers that prevent effective communication of medical histories, poverty, unemployment, lack of insurance, and limited access to health providers.

Wichita Eagle
December 12, 2002
Associated Press/Topeka Capital-Journal
December 12, 2002

PENNSYLVANIA

Single-payer Low-income Health Plan Expands

AdultBasic, a subsidized single-payer health insurance program for low-income workers and unemployed state residents, may open a waiting list early this year.

The program received $76 million from the state's share of the tobacco settlement for its first year of operation, July 2002 to July 2003, to provide health coverage for between 40,000 and 48,000 residents.

The health insurance plan requires participants to pay a $30 monthly premium for benefits that include hospital, emergency room, and physician visits for residents ages 19 to 64 with annual incomes less than $17,720 for individuals and less than $36,200 for a family of four.

Participants in AdultBasic pay co-payments of $5 for physician visits, $10 for specialist visits, and $25 for ER visits. The state has contracted with Keystone Health Plan East in greater Philadelphia; Capital Blue Cross/Pennsylvania Blue Shield in central Pennsylvania; Highmark/Western Caring Foundation in western Pennsylvania; and First Priority Health in northeast Pennsylvania to administer the program.

State Deputy Insurance Commissioner Patricia Stromberg said more than 37,000 state residents have enrolled, from an estimated 300,000 who qualify for the program.

After enrollment reaches capacity, the state will allow low-income residents who are above the income means test to apply for a spot on a waiting list to purchase the same health coverage provided under the program for $210.67 per month.

Philadelphia Inquirer
December 26, 2002

TEXAS

Tax to Pay for Uncompensated Care

University Health System officials in San Antonio have asked for a statewide quarter-cent sales tax to help fund uncompensated medical care provided in hospital emergency rooms. Dr. Ronald Stewart, trauma care director at University Hospital, said, "There needs to be some way to make certain the public safety need is met."

Such a sales tax could generate close to $600 million per year, which would go into a state health department special fund. The fund currently collects unclaimed lottery winnings and distributes the funds to hospitals providing indigent care.

Hospital districts and trauma centers around the state also have proposed implementing new fees on motor vehicle registrations, taxes on firearms and ammunition, and additional fines for people convicted of driving while intoxicated. At this writing, no bills had been filed in the legislature formalizing those proposals.

Houston Chronicle
January 2, 2003

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VIRGINIA

Medicaid Reimbursements To Be Frozen

Governor Mark Warner (D) announced a $1.2 billion budget proposal including nearly $83 million in cuts to the state's Medicaid program. By freezing reimbursement rates for hospitals, nursing homes, and HMOs treating Medicaid patients, the governor's office estimates it can save $61 million.

"To soften the impact of these actions," Warner pledged in his January state-of-the-commonwealth address, "the budget includes about $60 million—half of which is federal—to preserve access to health care. This funding would support special reimbursements to providers who are the sole source of medical services in their communities, or who serve disproportionate numbers of low-income Virginians."

Warner's budget proposal also calls for measures to "control the soaring cost of prescription drugs," hoping to save about $15 million if those controls are effective. The proposed controls include establishing a formulary for prescription drugs available to Medicaid patients; increasing the drug copayment required of Medicaid patients; decreasing fees paid to pharmacies to dispense prescriptions; and requiring prior authorization for drug purchases by nursing home residents who have many prescriptions.

Warner's proposal drew sharp criticism from several nursing home representatives.

"While we acknowledge that addressing our budget shortfall without additional revenues will force painful cuts to core services, balancing the budget on the backs of frail citizens is not the solution Virginia should pursue," said Stephen Morrisette, president of the Virginia Health Care Association, a nursing home trade group.

AARP Virginia President Ruth Nelson criticized Warner for not doing more to address unmet medical needs. Nelson was quoted in various media reports saying, "There are still a lot of Virginians that will not have health and long-term care as a result of the governor's recommendations."

Overall, the Warner budget proposed a $190 million net increase for health and human services, and State Senator John Chichester (R) predicted there will be "little resistance" to the plan by the 2003 General Assembly. The Assembly returned on January 8 for a six-week session, which is expected to be dominated by the governor's proposed budget.

Washington Times
Washington Post
Hampton Roads Daily Press
Richmond Times-Dispatch
all December 21, 2002

Recovered Medicaid Funds

In related news, federal and state officials collected almost $1.6 million in repayments from six Virginia medical transport operators indicted last year for overcharging Medicaid.

The six operators ran service vans to transport Medicaid beneficiaries to and from medical offices and hospital visits in the Richmond area. Virginia Attorney General Jerry Kilgore (R) said the Medicaid Fraud Control Unit became suspicious when it noted unusually high billing rates from the six operators.

The FBI and Internal Revenue Service joined the investigation, which included reviews of billing records, interviews with Medicaid beneficiaries, and undercover work. The operators pleaded guilty to federal charges under plea agreements that included jail time, restitution payment, and deportation to their native Sudan. The operators submitted false billings between $3 million and $4 million.

According to an Associated Press report published in the Newport News *Daily Press*, the money recovered was mostly in the form of travelers' checks the defendants intended to send overseas. An undisclosed amount of money had already been sent abroad and was not recovered.

"During hard budgetary times, I am truly honored to take this $1.6 million back for the commonwealth," Kilgore said.

Newport News Daily Press
December 17, 2002

Massachusetts Effort to Tax Prescriptions Leads to Chaos

CONRAD F. MEIER

A new tax on prescription drugs has come under heavy criticism from pharmacists, insurers, and consumer advocates. An estimated 55 million prescriptions will be subject to a tax of $1.30 for the remainder of the current fiscal year; the tax will fall to 65 cents per prescription July 1. Prescriptions filled for Medicaid and Medicare beneficiaries have been declared exempt.

The tax, which went into effect January 1, will be used to fund Medicaid and is expected to raise about $36 million annually.

In a December 30, 2002 hearing, pharmacists asked state officials to delay the tax, calling it "unfair, unclear, and certain to drive up the price of drugs for most Massachusetts residents." Pharmacists noted consumers could avoid the tax by using out-of-state or mail-order pharmacies. Also, pharmacists said they were unclear as to whether they should assess the tax when dispensing advice about over-the-counter drugs. Pharmacists said they often have difficulty determining whether a Medicare beneficiary's bill is being paid through traditional Medicare or through a Medicare+Choice plan; the former is exempt from the tax, while the latter is not.

Blue Cross and Blue Shield of Massachusetts has asserted federal government employees in its plan are exempt from the tax, and some hospitals contend their outpatient pharmacies should not be subject to the tax because they are licensed differently than retail pharmacies.

To add to the confusion surrounding the new tax, it is unclear whether the tax is incurred when the prescription is filled, or when it is picked up by the patient. It is not uncommon, pharmacists say, for a filled prescription never to be picked up, perhaps because the patient got better on his/her own, decided he/she couldn't afford the medication, or simply forgot to get it. There is also a question about whether prescription refills are subject to the tax.

Todd Brown, executive director of the Massachusetts Independent Pharmacists Association, said the tax regulations are ambiguous and "pharmacies will be unable to implement them as written."

Lee Tooman, vice president of government affairs for Golden Rule Insurance Company, was even more critical of the program. "I cannot imagine why a state would propose to tax prescription drugs to fund Medicaid," said Tooman. "Why would anyone want to drive up health insurance costs more than they already are? It looks to me like the state wants to put the burden of financing Medicaid on seniors and working people trying to pay for their medicines."

"It's not being called a tax. Instead, the state labels the $1.30 fee ... an assessment. But call a spade a spade. The assessment is a tax that will hurt the most vulnerable people in this state—the poor, the elderly and the middle-class."

EDITORIAL. *DAILY NEWS TRIBUNE* JANUARY 6, 2003

If it Looks Like a Tax ...

"It's not being called a tax," noted an editorial in the January 6 edition of the *Daily News Tribune*. "Instead, the state labels the $1.30 fee ... an assessment. But call a spade a spade. The assessment is a tax that will hurt the most vulnerable people in this state—the poor, the elderly and the middle-class."

On January 9, Massachusetts Attorney General Tom Reilly issued a news release warning pharmacies against "misrepresenting" the assessment. The assessment, he noted, is supposed to be paid quarterly by the pharmacies themselves, and they are not required by the law to pass along the assessment to customers. "These pharmacies are passing the buck," Reilly said. "These pharmacies have made that decision on their own. They are misleading consumers by making them think that they are required to collect this money."

Linda Ruthardt, the state commissioner of health care finance and policy, told the *Boston Globe* pharmacies should begin collecting the tax even though some details have not been finalized. A report in the January 2 issue of *DrugStore News* suggests the pharmacies will do just that, noting only B.J.'s Wholesale Club plans to "absorb" the new tax in its three pharmacies.

Michael Polzin, a spokesman for Walgreen Co., said his firm would "pass [the tax] on to customers. We'll be putting up signs in our pharmacies throughout the state, explaining what the tax is to consumers."

In light of the controversy and likelihood of prolonged court challenges, Ruthardt suggested pharmacies keep "detailed records" of who paid the tax, should it be repealed by the state legislature or deemed unconstitutional by the court.

Conrad F. Meier is managing editor of Health Care News.

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America Talks Health Care

TWILA BRASE

Tax credits and Medical Savings Accounts took center stage at the Bush administration's first "Talk to Tommy" public forum on health care, held December 10, 2002 in Minneapolis. Similar meetings are being held across the country, including one held December 17 in Jacksonville, Florida to focus on doctors and medical malpractice issues.

Billed as *America Talks Health Care*, the event featured Tommy Thompson, secretary of the Department of Health and Human Services, and two panel discussions addressing individual control and ownership of health insurance.

Thompson invited the audience of approximately 250 people to share any ideas for improving health care, no matter how radical. "Health care is the number one issue facing Americans today," he said. The Bush administration plans $117 billion in new health care initiatives, Thompson noted, including tax credits, health accounts, and association health plans. Health insurance, he said, should be accessible, accountable, and affordable.

Provocative Panels

Russell Hagen, CEO of Data Recognition Corporation (DRC), described during one of the panel discussions the menu of health benefits his company offers to its employees, and how enrollment in the various plan options has changed in recent years. As insurance premiums have increased, he noted, enrollment in the company's most expensive plans has fallen. Nevertheless, only 17 percent choose the company's major medical plan, which costs 43 percent less than the highest-priced plan.

DRC is unusual in that it will not allow its employees to be uninsured. Employees are enrolled automatically, and their share of premium payments is deducted from their paychecks, unless they present a letter to human resources stating they are enrolled in a spouse's health plan.

"It's a bit paternalistic, but tough bounce," Hagen admitted. His primary goal, he said, is a healthy workforce.

"The Bush administration plans $117 billion in new health care initiatives, [HHS Secretary Tommy] Thompson noted, including tax credits, health accounts, and association health plans."

Panelist Grace-Marie Turner, president of the Galen Institute, discussed tax reform as key to increasing consumer choice and the share of the U.S. population covered by insurance. Although employers receive tax deductions for providing health insurance to employees, "millions of women believe they could pick a better policy than the HR department," she noted. Tax credits would make it financially possible for individuals to purchase policies that suit their needs better than the one-size-fits-all employer-provided group policies.

Saying the number of uninsured would drop by half, Turner advocated refundable tax credits that would target the uninsured, while not disturbing those with existing coverage. She emphasized, "Whoever controls the money controls the choices."

John Goodman, president of the National Center for Policy Analysis (NCPA), charged the federal tax code with being "very biased against people being allowed to control health care dollars." He revealed "tax law is encouraging us all to be in HMOs."

"We need a use-it-or-save-it account," Goodman said, because "nobody cares about you more than you care about you."

David Hess, corporate vice president for benefits at Medtronic, and Carla Bender, a Medtronic employee, discussed Health Reimbursement Arrangements. Since it began offering Definity Health's HRA plan, Medtronic's costs have decreased. Employees choose generic drugs more often, and they use the company's nurse line more often to address relatively minor health issues. To Bender's relief, Definity allows her to "know the exact financial obligation" of any procedure.

Medical Savings Accounts

Kallija Paraska, senior vice president for Accordia Northwest, a Seattle-based insurance brokerage firm, discussed Medical Savings Accounts as a way to significantly reduce health insurance costs. She said she can provide a Washington State employer with an MSA plan for just $103 per employee per month, compared to at least $312 per employee per month for standard insurance policies.

Thirty-four percent of MSA enrollees are senior citizens, who use their MSAs primarily for prescription drug coverage. According to Paraska, the cost of an MSA plan for seniors is $175 per month. Accordia's MSA enrollees have seen premium increases of no more than 5 percent. One CEO with 24 employees used Accordia to switch to MSAs. The company's $89,000 annual health insurance expense dropped to $51,000. Part of the savings went to the employees, and $13,000 went to support the company's bottom line.

Public health nurse Twila Brase, president of Citizens' Council on Health Care, writes a regular column on health care issues for The Heartland Institute's quarterly public policy magazine, Intellectual Ammunition. *She can be reached by email at* twila@cchc-mn.org. *More information about CCHC can be found on its Web site at* http://www.cchconline.org

MAINE continued from page 1

Medicaid waiver approved by the federal government on January 18, 2001, the Healthy Maine program provided discounts of as much as 25 percent on prescription drugs for about 108,000 uninsured Maine residents with incomes less than 300 percent of the federal poverty level who do not qualify for Medicaid.

"The Healthy Maine Prescriptions program was adopted in part as a response to court challenges to Maine Rx, a prescription drug program adopted by the state—and immediately met with a lawsuit—in May 2000. ... [T]the U.S. Supreme Court ... in June 2002 agreed to hear the case."

Shortly after the legislature approved the program, PhRMA filed suit in federal court to block its implementation. But in February 2002, U.S. District Court Judge Ricardo Urbina approved the program. PhRMA appealed.

Maine policymakers modified the plan after the District of Columbia Circuit Court overturned a similar Vermont program. Maine lawmakers tried to distinguish their program from Vermont's by agreeing to pay from tax dollars 2 percent of the cost of prescriptions filled through the program.

PhRMA attorney John Roberts said the U.S. Department of Health and Human Services (HHS) never approved the state's contribution to Healthy Maine. The appeals court's three-judge panel agreed, deciding Healthy Maine was therefore an "illegal expansion of Medicaid." Wrote Judge Harry Edwards, "To the extent that the modified Maine program purports to be different from the flawed Vermont program, it has yet to be considered or approved by the federal government."

Response

PhRMA officials were pleased with the Circuit Court's ruling. Noted spokesperson Bruce Lott, "As they did in the [Vermont] case a year ago, the court has ruled that this type of program violates Medicaid law."

State officials said they did not believe the decision means the program must "shut down." They plan to address the court's concerns by working with state legislators and HHS Secretary Tommy Thompson to modify the plan.

While Pine Tree State officials grapple with the rejection of Healthy Maine, another battle looms. The Healthy Maine Prescriptions program was adopted in part as a response to court challenges to Maine Rx, a prescription drug program adopted by the state—and immediately met with a lawsuit—in May 2000.

PhRMA argued Maine Rx violated the Commerce Clause of the U.S. Constitution. While the District Court agreed, the First Circuit Court of Appeals reversed, finding Maine Rx regulates only in-state activities. PhRMA appealed to the U.S. Supreme Court, which in June 2002 agreed to hear the case. Briefs have been filed, and the case is on the docket for this term.

For more information...

WWW The full text of the U.S. Circuit Court of Appeals for the District of Columbia's decision in *Pharmaceutical Research and Manufacturers of America v. Tommy G. Thompson* is available through *PolicyBot*. Point your Web browser to **http://www.heartland.org**, click on the *PolicyBot* icon, and search for document #**11469** (5pp.)

Briefs submitted to the U.S. Supreme Court in *Pharmaceutical Research and Manufacturers of America v. Concannon et al.* are also available through *PolicyBot*. Request documents #**11470** (PhRMA reply brief, 22pp.), #**11471** (amicus curie brief submitted by Pacific Legal Foundation, 37pp.), and #**11472** (amicus curie brief submitted by Solicitor General, 43pp.).

Conrad F. Meier is managing editor, and Diane Carol Bast is editor, of Health Care News.

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The Galen REPORT

GALEN INSTITUTE

A MONTHLY REVIEW OF HEALTH POLICY MATTERS

President George W. Bush is meeting with congressional leaders, White House staffers are working around the clock, and the question everyone is asking is: What are they deciding about spending proposals for Medicare, prescription drugs, and the uninsured?

The decisions being made now will launch the debate over hugely consequential health care issues. The President told leaders he will put substantially more than $190 billion into his budget for a drug benefit, and he and aides have said repeatedly the benefit will be incorporated into other improvements in the Medicare program.

"The decisions being made now [by the President and other political leaders] will launch the debate over hugely consequential health care issues."

What could be at risk, however, is money for the uninsured. Census Bureau figures issued in late September put political leaders under growing pressure to take action. The battles will be over providing new free-market tax incentives or taking the all-too-easy path of further expanding old government programs.

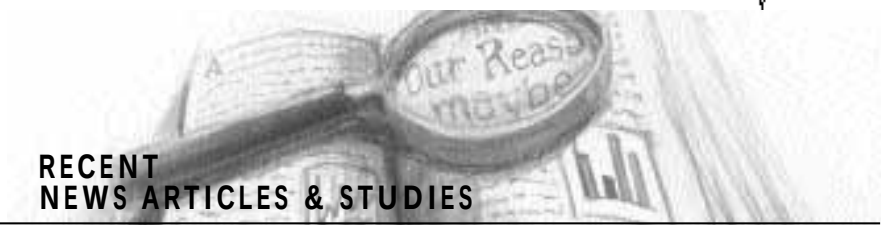
Even as we write, consequential decisions are being made by the administration about global protection of intellectual property rights. Activists are pressing hard in World Trade Organization talks to further expand authority to pirate drug patents, putting research and development in the pharmaceutical industry at risk.

The activists' real target is global capitalism, and undermining intellectual property is their strategy. Property rights are a cornerstone of the economy of any developed or developing economy. Leaders must decide if this country will continue to fight for this essential protection in these talks and also in the coming debate in Congress over giving seniors access to cheaper generic drugs.

As Kate O'Beirne asked in a recent column in *National Review*, "There are over 400 new anti-cancer drugs being researched; scores of others are being studied in the hope of treating Alzheimer's and diabetes. Which of these does the public want to see canceled for lack of research funds?"

— Grace-Marie Turner

Material for this report is provided by The Galen Institute, P.O. Box 19080, Alexandria, VA 22320, http://www.galen.org. Grace-Marie Turner is president. The report was produced by Elizabeth Lamirand, who can be reached at 703/299-9550, and edited by Conrad F. Meier, managing editor of *Health Care News*.



RECENT NEWS ARTICLES & STUDIES

Covering America: Real Remedies for the Uninsured, Volume 2

Tom Miller; David B. Kendall, Jeff Lemieux, and S. Robert Levine; James A. Morone
Economic and Social Research Institute, 12/02

Covering America promotes serious consideration of a diverse range of comprehensive proposals to provide affordable health coverage for millions of uninsured Americans.

Tom Miller of the Cato Institute proposes a reformed health care system that would promote efficiency and economy by redesigning market incentives, especially for individual consumers, as well as using tax credits and safety net reform to remove financial barriers to getting care. "Market-based reform begins with more neutral tax treatment of health insurance purchasing options, emphasis on protection against major risks, and deregulation of health care suppliers," writes Miller.

David Kendall, Jeff Lemieux, and S. Robert Levine, of the Progressive Policy Institute, offer an option that builds on the present system, but provides substantial tax credits to make coverage more affordable. This plan includes performance-based grants to states linked to improvements in coverage rates, access to care, health care quality, outcomes, public health, and protection from financial hardship.

Full text: http://www.esresearch.org/publications.php

Scandlen, Francis Testify on FEHBP Improvements

Greg Scandlen and Walton Francis
Testimony to the Subcommittee on the Civil Service, Census and Agency Reorganization, 12/11/02

Greg Scandlen and Walton Francis were among the witnesses at a December 11 hearing before the House Civil Service Subcommittee chaired by Representative Dave Weldon, MD (R-Florida). The hearing focused on "Recent Developments in the Federal Employees Benefits System" and what further improvements could be made.

Scandlen and Francis shared a panel with representatives from four unions: the National Treasury Employees Union, the American Federation of Government Employees, the National Association of Retired Federal Employees, and the American Postal Workers Union.

All the unions except APWU expressed skepticism about increasing consumer power in health care, especially medical savings accounts, which they said benefit only the "healthy and wealthy." APWU has recently begun offering a consumer-directed health plan to federal workers, but even they opposed MSAs for federal workers.

Scandlen said the charge that MSAs benefit only the healthy and wealthy is completely false and is rebutted by all the available research. He added the FEHBP could learn from what the private sector is doing, including the movement towards consumer-driven plans, using a fixed contribution, and encouraging more private indemnity plans.

Francis noted the FEHBP "outperforms" many private-sector benefit programs, but still needs significant improvements, including a fixed federal contribution to encourage selection of lower-cost options, fewer mandates, better coordination with Medicare, and more choices of plan designs.

Full text of Scandlen testimony: http://www.galen.org/news/ScandlenTestimony.doc
Full text of Francis testimony: http://www.galen.org/news/Francistestimony.doc

Hospitals Are Just Playing the Medicare Game

Chris Middleton
Health Policy Prescriptions, 12/02

"Gaming the system has always been part and parcel of the federal Medicare program," says Chris Middleton of the Pacific Research Institute. Hospitals and other providers are tempted to exploit the program's flaws because "Medicare's price control system is clumsy and easily manipulated."

Tenet Healthcare Corp., for example, is accused of overcharging Medicare and contributing to overall medical inflation by listing high retail prices. "The continued gaming of Medicare's bureaucrat-controlled price system provides one more reason to transform Medicare into a defined contribution program of competing private insurance plans," concludes Middleton.

Full text: http://www.pacificresearch.org/pub/hpp/2002/hpp_02-12.html

Health Insurance Tax Credits: Will They Work for Women?

Sara R. Collins, Stephanie B. Berkson, and Deirdre A. Downey
The Commonwealth Fund, 12/02

A new study by The Commonwealth Fund reports researchers searched the Internet in 25 cities to find low-deductible, comprehensive health insurance for $1,000 to $1,500 a year. Not surprisingly, they found a wide range of options: $1,000 would buy a 35-year-old woman a policy in Nashville, Tennessee with a $5,000 deductible. In California, the same person could buy a policy with a $500 deductible—primarily revealing the distortions in the individual market caused by state regulation and mandates.

The apparent intent of the study is to discredit tax credits by showing they would be useless in helping low-income women afford coverage. But buried in the study is an admission that the tax credit would cover half the cost of the premium for a comprehensive, low-deductible policy in many of the cities studied.

Professor Mark Pauly of the University of Pennsylvania Wharton School has produced studies showing providing a tax credit worth half the value of a decent health insurance policy would encourage half of those eligible for the credit to obtain insurance. If purchasers tolerated higher deductibles, even more could purchase coverage.

It is important to pay attention to the needs of the poorest and sickest uninsured. Studies like this one, which focus only on worst-case scenarios, distort the debate and could deny millions of people—many of them women—the opportunity to have the security of insurance coverage for themselves and their families.

Full text (pdf): http://www.cmwf.org/programs/insurance/collins_creditswomen_589.pdf

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My TURN

BY CONRAD MEIER - MANAGING EDITOR

Reaping What They Sued

CONRAD F. MEIER

Approximately $32 billion has been paid out since the national tobacco settlement was reached in 1998. Most of the money has been used to finance things unrelated to smokers' health care, health care in general, or smoking prevention programs.

Antismoking activists once claimed the landmark $246 billion settlement was "a major victory" for public health. Today they and the rest of us are reaping what they sued.

Broken Promises

A recent study from Yale University, published in the October 3, 2002 issue of the *New England Journal of Medicine*, reveals the big lie: Almost none of the tobacco settlement money has been spent for health care or prevention-cessation programs.

By comparing state tobacco control program expenditures with settlement payments for 2001, lead author Cary Gross M.D. and colleagues conclude less than 6 percent of the settlement funds were directed to tobacco-related programs.

The Centers for Disease Control and Prevention (CDC) recommended states spend from $5 to $15 per person, or roughly 20 percent of the settlement money, on tobacco control programs. The Yale University researchers found most states aren't even spending half that amount. Only Arizona, Hawaii, Indiana, Maine, Massachusetts, and Mississippi spent more than the CDC recommendations on tobacco programs last year.

According to Bill Core, executive vice president of the Campaign for Tobacco-Free Kids, only about 4 percent of the settlement monies paid out for fiscal year 2002 will be spent on tobacco prevention and cessation, compared with a high of 9 percent in 1999. Core said, "I think it is fair to say that even prior to the economic downturn most states were not even close to living up to the promises that were made."

"By comparing state tobacco control program expenditures with settlement payments for 2001, [Yale University researchers] conclude less than 6 percent of the settlement funds were directed to tobacco-related programs."

The "major victory" for public health has given way to a spending spree on what cannot honestly be called health care- or smoking-related matters, paid for entirely by smokers.

Great American Smoking Scam

Payments from the settlement were originally agreed to be made over 25 years, but 15 states have already sold their rights to some or all future payments in an effort to get quick cash for balancing over-spent budgets or for spending on political pork. As the New Year turned one day old, Governor Bob Holden's (D-Missouri) administration announced the state would try to sell its rights to all future revenue in order to balance a bankrupt budget and keep past spending promises.

Settlement dollars have been used to pay for new schools in New Hampshire, property tax rebates in Illinois, and college scholarships in Michigan. Millions of settlement dollars have been spent to build and improve harbors in Alaska, while North Dakota has spent most of its early settlement money on flood control.

North Carolina, perhaps with an eye toward giving something back to the smokers whose money is financing the settlement, spent $40 million to upgrade tobacco farmers' curing furnaces so they could produce better tobacco. In a defense of the move, Tennessee House Majority Leader Phil Baddour (D) told CBS News the "economic health" of the state is dependent on tobacco. "We are doing a good thing," he said.

Less comprehensible, perhaps, are the decisions by seven states to invest a portion of their settlement funds in tobacco company stocks.

Victims of Extortion

While the tobacco settlement agreement may have served the political interests of many state attorneys general and padded the wallets of private contingency fee lawyers, it has become obviously harmful to our civil rights and economic freedoms.

The tobacco settlement forced about a $1 per pack increase in the retail cost of cigarettes, to which states are adding more taxes in the name of ... you guessed it ... health care. The tobacco settlement has been kneaded into a very regressive tax on the people who can least afford the cost and who tend to need health care the most, but has done little or nothing to ensure they get it.

Because of a deal in which they had no say, smokers in states that signed onto the bargain may not litigate as a class, sue for punitive damages covering past acts, or collect compensatory damages in excess of an agreed-upon cap.

The peculiar logic and law of the tobacco settlement has opened the door for even more "public health"-related contingency lawsuits, like those aimed at the fast-food industry for its alleged role in creating an obese nation. The trial lawyers are hoping to find 12 jurors willing ignore the reality that people freely choose to eat their way to obesity, as they eventually found 12 willing to say smokers weren't aware of the risk cigarettes posed to their health.

When it comes to the behavior of our fellow citizens, we appear to have abandoned the principles of free choice and personal responsibility, in favor of big-brother regulatory mandates and self-serving forgiveness for the consequences of individual lifestyle choices. The consequences for our health as well as our freedom can only be bad.

Conrad F. Meier is managing editor of Health Care News.

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